

**Semi-Annual Report to the
Joint Legislative Oversight Committee
on Mental Health, Developmental Disabilities and Substance Abuse Services
on**

**Mental Health, Developmental Disabilities and Substance Abuse Services
Statewide System Performance Report
SFY 2007-08: Spring Report**

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

April 1, 2008

**North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in the previous reports.

Domain 1: Access to Services – Among all the age-disability groups, children with mental illnesses are fairing the best in terms of services being provided to them. Just over 40% of children with mental illness are provided services by the public system compared to slightly over one-third of adults with mental illness and adults with developmental disabilities. The lack of services to persons with substance abuse problems (less than 10% of those in need for both adolescents and adults) continues to be an area of significant concern. Over the past two calendar years, the timeliness of initial services for routine care has slightly decreased (from 69% to 62%).

Domain 2: Individualized Planning and Supports – The large majority of consumers with developmental disabilities report having some input in how they spend their day, money and free time (very similar to consumers in all participating states). Consumers with mental health and substance abuse disorders (regardless of age-disability group) overwhelmingly report having a choice in their provider. The majority of families of consumers with developmental disabilities report having enough information to assist in service planning for their family members. For mental health and substance abuse consumers, the large majority of children and adolescents report family involvement in planning and treatment but this is not the case for adult consumers.

Domain 3: Promotion of Best Practices – A new tiered waiver system is currently being developed for developmental disability consumers. The development of the tiered waivers is an opportunity to enhance best practice approaches to delivering services and supports for individuals who experience developmental disabilities. For mental health and substance abuse consumers, the last several quarters have shown increases in the use of best practice services for both child and adult consumers.

Domain 4: Consumer-Friendly Outcomes – Over three-fourths of North Carolina families of consumers with developmental disabilities (either living at home or away from home) believe services have made a positive difference in their family member's life (rating higher than reports from family members in all other states). Mental health and substance abuse consumers report that services have helped them improve their education, housing, and employment (although, in most circumstances, adult substance abuse consumers report more improvement than the other groups).

Domain 5: Quality Management Systems – Per legislation in 2007, the Department of Health and Human Services is reporting on the use of community support services. As part of this, Local Management Entities (LMEs) completed post-payment reviews for 777 providers in September 2007. Providers are also being referred for further review. In addition, A successful quality management conference on building sustainable collaborations was held in August 2007.

Domain 6: System Efficiency and Effectiveness – Local management entities continue to exceed requirements for submission of consumer information to the Division. Six LMEs have received single stream funding for all of SFY 2008. As of January, only three of them have reported the expected volume of services as "shadow claims." Information on units of services provided, associated costs, and consumers served are collected utilizing the State Claims Processing Systems, IPRS and Medicaid. Local Management Entities that receive single-stream funding for State-funded services or that participate in certain Medicaid Waivers do not use the claims system to receive payment for services provided. In order to capture information about the services provided, the state has instructed these LMEs to submit "shadow

claims" for services provided (claims for which they do not expect to be paid). The claims processing system fiscally denies these claims (showing amount paid as \$0), but captures relevant information about services provided. This allows the state to monitor publicly funded services funded by Medicaid and State funds.

Domain 7: Prevention and Early Intervention – Through the Safe and Drug Free Schools and Communities program, North Carolina provided educational and prevention services to almost 2,000 young people in SFY 2006-07 across fourteen LMES and in sixteen different evidence-based programs.

Table of Contents

LEGISLATIVE BACKGROUND.....	5
MEASURING STATEWIDE SYSTEM PERFORMANCE.....	5
DOMAIN 1: ACCESS TO SERVICES.....	6
<i>Measure 1.1: Persons Receiving Community Services.....</i>	<i>7</i>
<i>Measure 1.2: Timeliness of Initial Service</i>	<i>9</i>
DOMAIN 2: INDIVIDUALIZED PLANNING AND SUPPORTS	11
<i>Measure 2.1: Consumer Choice</i>	<i>11</i>
<i>Measure 2.2: Person-Centered Planning.....</i>	<i>13</i>
DOMAIN 3: PROMOTION OF BEST PRACTICES	15
<i>Measure 3.1: Persons Receiving Evidence-Based Practices.....</i>	<i>16</i>
<i>Measure 3.2: Management of State Facility Usage</i>	<i>18</i>
<i>Measure 3.3: Continuity of Care Following Discharge from State Facilities</i>	<i>20</i>
DOMAIN 4: CONSUMER-FRIENDLY OUTCOMES	22
<i>Measure 4.1: Outcomes for Persons with Developmental Disabilities</i>	<i>23</i>
<i>Measure 4.2: Outcomes for Persons with Mental Health Disorders.....</i>	<i>23</i>
<i>Measure 4.3: Outcomes for Persons with Substance Abuse Disorders.....</i>	<i>24</i>
DOMAIN 5: QUALITY MANAGEMENT SYSTEMS	25
<i>Measure 5.1: Assurance of Basic Service Quality.....</i>	<i>26</i>
<i>Measure 5.2: Quality Improvement Activities</i>	<i>28</i>
DOMAIN 6: SYSTEM EFFICIENCY AND EFFECTIVENESS	28
<i>Measure 6.1: Business and Information Management.....</i>	<i>29</i>
<i>Measure 6.2: Efficient Management of Service Funds.....</i>	<i>30</i>
DOMAIN 7: PREVENTION AND EARLY INTERVENTION	31
<i>Measure 7.1: Safe and Drug Free Schools and Communities.....</i>	<i>32</i>
APPENDIX A: SAMHSA NATIONAL OUTCOME MEASURES.....	33
APPENDIX B: CMS QUALITY FRAMEWORK.....	34
APPENDIX C: DESCRIPTION OF DATA SOURCES	35

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2007-08: Spring Report

Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

“The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals....”

In addition, NC G.S. 122C-102(c) was revised to read:

“The State Plan shall also include a mechanism for measuring the State’s progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State’s progress in these performance areas.”

The following builds on the measures reported in previous semi-annual reports. The Division of Mental Health, Developmental Disabilities and Substance Abuse Service is currently developing measures of progress on strategic objectives to be achieved in the next three fiscal years. Future semi-annual reports will provide updates on each of the selected strategic objectives as they relate to the domains established by the Legislature.

Measuring Statewide System Performance

The October 2006 report described initiatives that the Division has undertaken over the past several years to create a foundation for quality management. The Division’s accomplishments in improving its information and quality management systems are necessary foundations for the data included below.

As of July 1, 2007, six out of twenty-five local management entities (LMEs) had moved to single-stream funding, which provides them with service fund allocations prior to service delivery. Instead of submitting claims for reimbursement of services that have been delivered, these LMEs are required to report “shadow claims” after delivery of those services. As of the date of this report, three additional LMEs have begun receiving single-stream funding. Because of the continued move toward this flexible funding mechanism, the quality and completeness of information on the service system in future reports will depend on LMEs’ compliance with requirements for submission of “shadow claims.” See Measure 6.2 for more information.

The domains of performance written into legislation reflect the goals of the President's New Freedom Initiative and national consensus on goals all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division continues to refine performance measures to evaluate the implementation of system reform efforts and its impact on system performance and consumers' lives. The Division is choosing measures that relate to:

- The goals of *The State Strategic Plan: 2007-2010*.
- SAMHSA National Outcome Measures (NOMS) (See Appendix A for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix B for details).
- Performance requirements specified in the *SFY 2008 DHHS-LME Performance Contract*.

The performance measures chosen for this report to the Joint Legislative Oversight Committee are a result of continuing work in this effort. For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system reform efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
 - A description of the indicator(s) used for the measure.
 - The most recent data available and an explanation of trends and patterns in the data.
 - Division expectations about future trends and plans for addressing problem areas.

Appendices at the end of this report provide information on the data sources for the information included in each domain.

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. Timely access is essential for helping to engage people in treatment long enough to improve or restore personal control over their lives, and to prevent crises. Both the SAMHSA National Outcome Measures and CMS Quality Framework include measures of consumers' access to services.

Measure 1.1: Persons Receiving Community Services

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population (*prevalence*). (See Appendix C for sources.) Based on the most recent estimates,² every year:

- Approximately 12% of children and adolescents (ages 9-17) and 5.4% of adults (ages 18 and older) face serious mental health (MH) problems. Although no estimates for children under age 9 have been established, studies include estimates ranging from 11% to 18%.³
- Prevalence rates for developmental disabilities (DD) vary across age groups and decrease as the population ages. According to most recent estimates, the prevalence rates are as follows: ages 3-5 = 3.8%; ages 6-16 = 3.2%; ages 17-24 = 1.5%; ages 25-34 = 0.9%; ages 35-44 = 0.8%; ages 45-54 = 0.7%; ages 55-64 = 0.5%; ages 65 and older = 0.4%.
- Approximately 7.2% of adolescents (ages 12-17), 17.3% of young adults (age 18 to 25), and 6.3% of older adults (age 26 and above) face serious substance abuse (SA) problems.

Applying these estimates to North Carolina's populations translates into almost 342,000 NC adults needing mental health (MH) services and almost 560,000 needing substance abuse (SA) services each year. Approximately 50,000 adults need services and supports for a developmental disability (DD).⁴

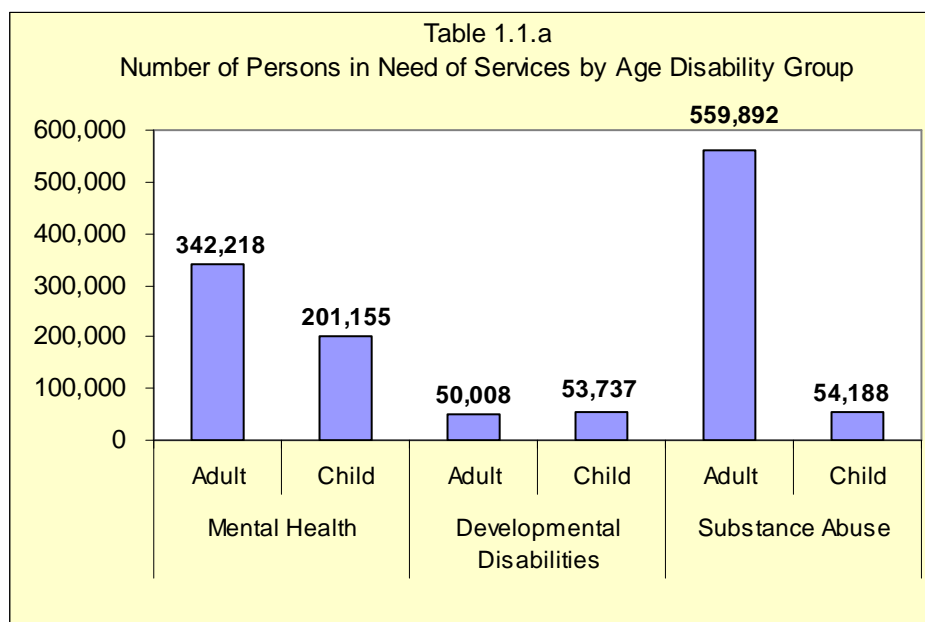
Assuming the 12% prevalence rate for older youth (ages 9-17) also applies to children under age 9, approximately 201,000 children experience MH problems each year that, if not addressed, can lead to a MH disorder. Almost 54,000 children and adolescents (ages 0-17) in North Carolina have a developmental disability and another 54,000 adolescents (ages 12-17) experience a diagnosable SA disorder.

The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings. Tracking the number of persons in need who receive community-based services (*treated prevalence*) through the public MH/DD/SAS system provides a barometer of progress on that goal.

² These estimates are updated regularly to reflect the most recent information provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and research on developmental disabilities. See the Appendix C for source information.

³ The Division applies the estimates established for ages 9-17 to all children ages 0-17 to estimate the numbers of North Carolina children and adolescents in need of mental health services. See Appendix C for more information.

⁴ The numbers presented here include all persons in North Carolina estimated to need mh/dd/sa services, including those who may be served by private agencies or other public systems.



SOURCE: State Demographics Unit, July 2007 Population Projection. See Appendix for source of disability-specific prevalence rates.

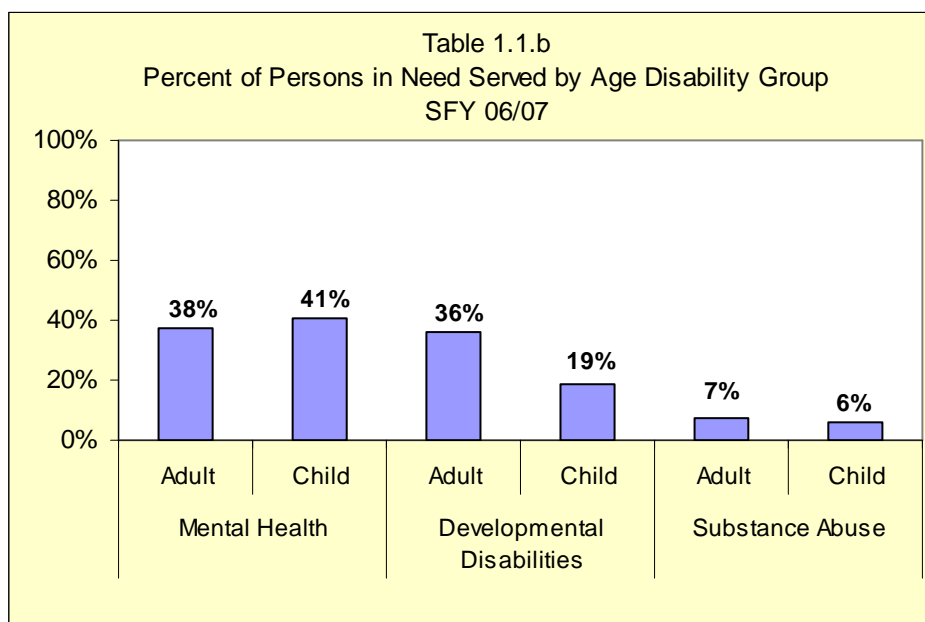
Not all persons in need of MH/DD/SA services – especially those with mental health and/or substance abuse issues – will seek help from the public system. Those who have other resources, such as private insurance, will contact private providers for care. However, many will not seek help at all, due to a lack of knowledge of what services are available or how those services can help. In addition, cultural stigmas against admitting problems and distrust of governmental programs keep others from seeking help.⁵ **The Division is focused on improving services to individuals currently served in the public system, while increasing access to others who need services.**

Table 1.1.b on the following page, presents the percent of persons in need who received publicly-funded community-based services during the last state fiscal year.⁶ This percentage provides information that the Division uses to establish reasonable targets and to evaluate the need for future changes to fiscal or programmatic policies.

As seen in Table 1.1.b., the state's public system serves only 7% of adults with substance abuse disorders compared to approximately 38% of adults with mental health disorders and 36% of adults with developmental disabilities. This is, in part, a reflection of the greater access to Medicaid services individuals with mental health disorders and developmental disabilities have in comparison to individuals with substance abuse disorders.

⁵ The Division of MH/DD/SAS is charged with serving persons ages 3 and above. The Division of Public Health is responsible for all services to children from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21. The LME Administrative Cost Model, developed by Anthony Broskowski and used as a basis for LME funding, assumes that 48% of adults and 40% of children in need will be served through the public MH/DD/SAS system.

⁶ The number of persons in need of services (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA).



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2007.

The state serves 41% of children and adolescents (ages 3-17) who need mental health (MH) services and 19% of children and adolescents (ages 3-17) needing developmental disabilities (DD) services. Approximately 6% of adolescents (ages 12-17) in need of substance abuse (SA) services receive them through the state's MH/DD/SA service system.

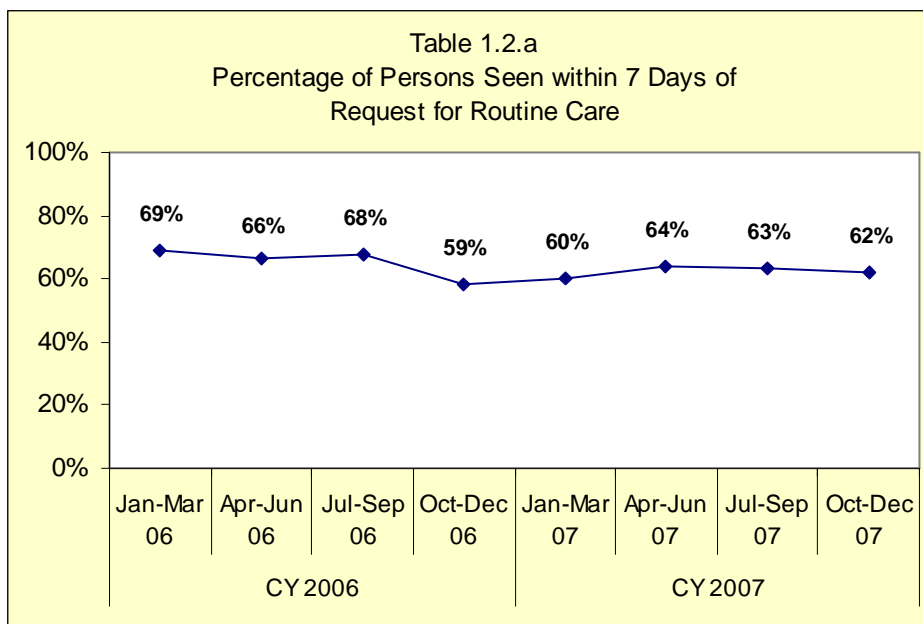
The Division is currently working with the North Carolina Institute of Medicine to design and implement new strategies to better identify and engage individuals in need of substance abuse services.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure⁷ that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that results in more trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

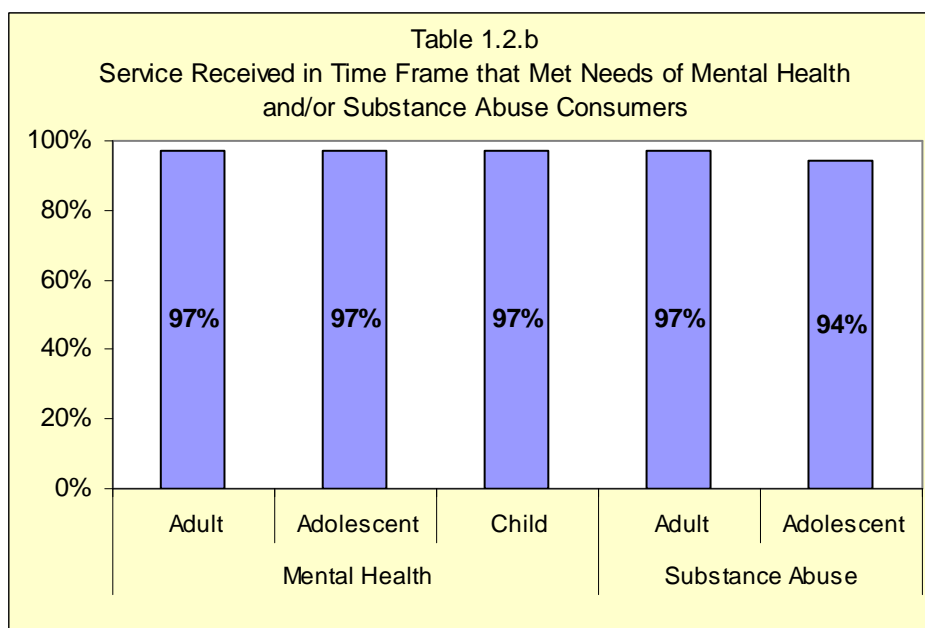
Table 1.2.a on the next page, shows a decrease in the percentage of consumers who seek routine (non-urgent) care and are actually seen by a provider within seven days of requesting services (a drop from 69% to 62% over the past two calendar years). However, the percent of those who are seen within two hours in emergency situations and within 48 hours in urgent situations continues to be over 99% and 79% respectively (not shown).

⁷ Health Plan Employer Data and Information Set (HEDIS©) measures.



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS, published in Quarterly Performance Contract reports.

In addition, as shown in Table 1.2.b below, almost all mental health and substance abuse consumers reporting outcomes data in SFY 2006-07 stated that services were received in a time frame that suited their needs.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2006 - June 30, 2007.

The Division continues to work with LMEs to reach the established goal of having 85% of consumers receive their first services in a timely fashion. The Division has historically measured timeliness of routine service as being seen within seven days of request, as reported above. However, HEDIS considers a routine service as timely if delivered within 14 days of request. The *SFY 2008 DHHS-LME*

Performance Contract adopted the HEDIS timeframe for requirements of LMEs. Future measures of routine services presented herein will also use the HEDIS 14-day timeline.⁸ **The Division expects future reports to show that a greater percent of consumers are meeting the more realistic expectations set by HEDIS than has been seen using the more stringent North Carolina requirement.**

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to the individual – and their family, where appropriate – are more likely to engage them in service and encourage them to take charge of their lives. Services that address what is important for them produce good life outcomes more efficiently and effectively.

The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice

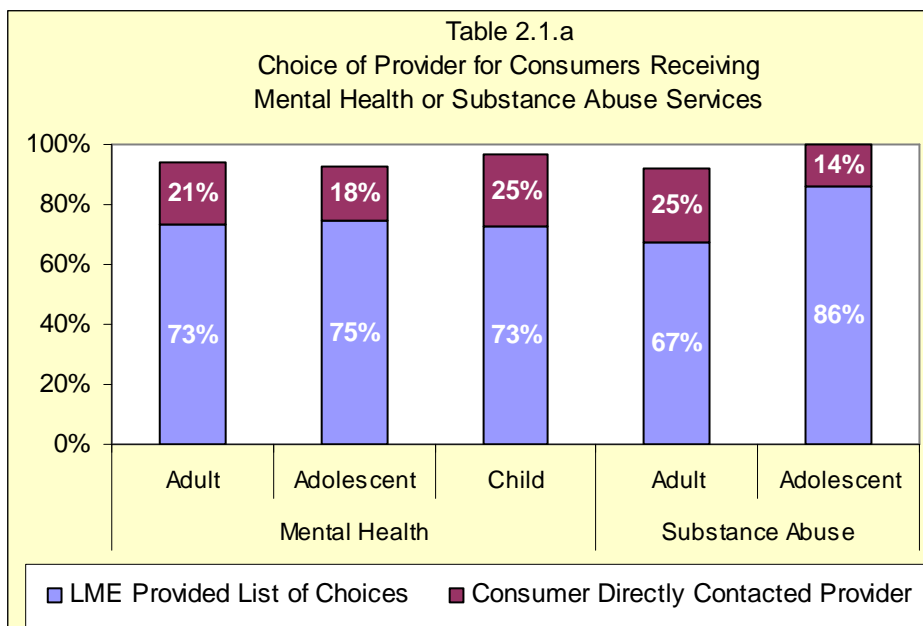
Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. The identification of qualified providers began in earnest with the implementation of new service definitions on March 20, 2006. As of December 2007, the LMEs had almost 2,900 active agencies providing community-based services across the state.⁹

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.a): Finding the right provider and situation can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive.

About three-fourths of mental health consumers (regardless of the age group) and two-thirds of adult substance abuse consumers reporting outcomes data in SFY 2006-07 said that the LME gave them a list of providers from which to choose services. Among all the age-disability groups, adolescent substance abuse consumers were most likely to report being provided a list of choices (86%). (See Appendix C for information on NC-TOPPS).

⁸ Timeframes for initiation of emergent and urgent services, which already match HEDIS, will not be altered.

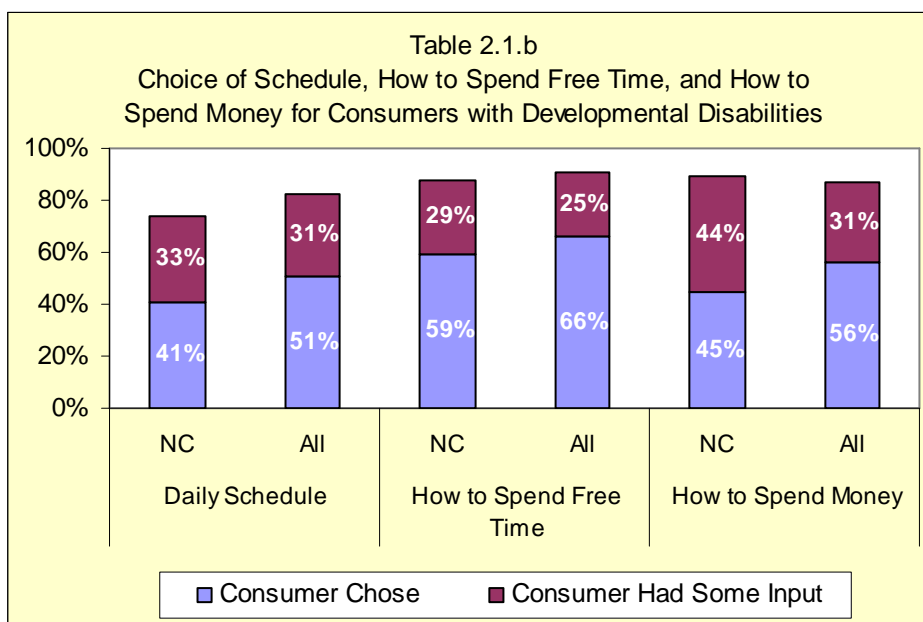
⁹ See Appendix C for details.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2006 - June 30, 2007.

Consumers with Developmental Disabilities (Table 2.1.b): Having a choice of providers, while important, is not the only component of control consumers seek. Having control of one's life also requires being able to exercise choice in making both major and routine life decisions.

In SFY 2005-06 interviews, an overwhelming majority of consumers with DD reported choosing or having some input in how they spend their day (74%), free time (88%), and money (87%), much like consumers from other states participating in the project. (See Appendix C for more information on this survey.)



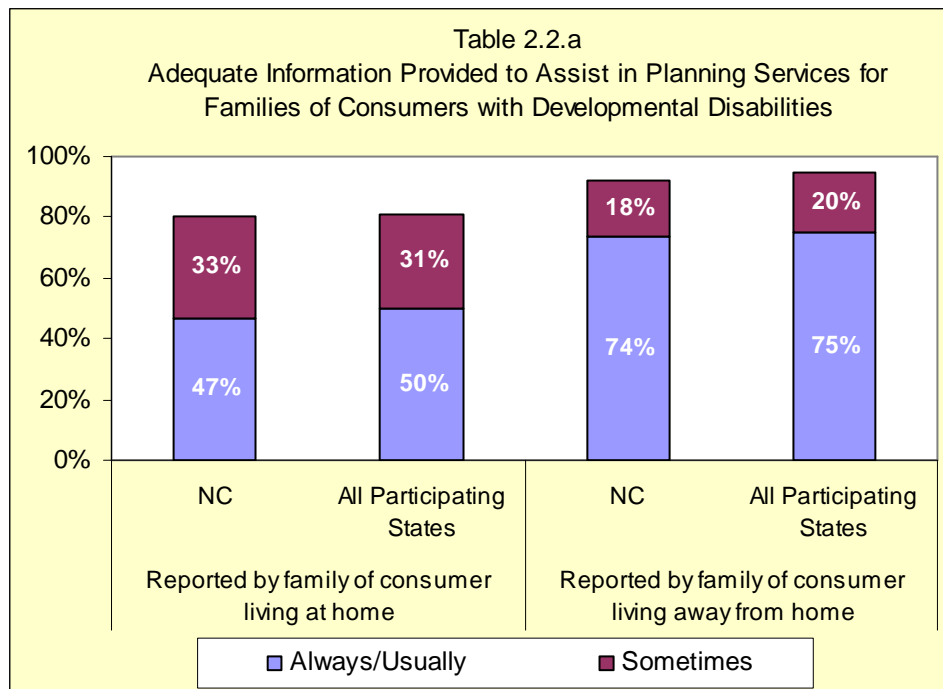
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2005-06.

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. The Division requires a PCP for individuals who receive publicly-funded community intervention services and has implemented a standardized format and conducted training to ensure statewide adoption of this practice.

As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

Consumers with Developmental Disabilities (Table 2.2.a): In regard to service planning for families of consumers with developmental disabilities, about three-fourths of North Carolina families of consumers who live *away from home* reported always or usually having enough information to help them participate in planning services for their family member, compared to slightly less than half (47%) of North Carolina families of consumers who live *at home*. North Carolina families responded similarly to families in all states using the survey.

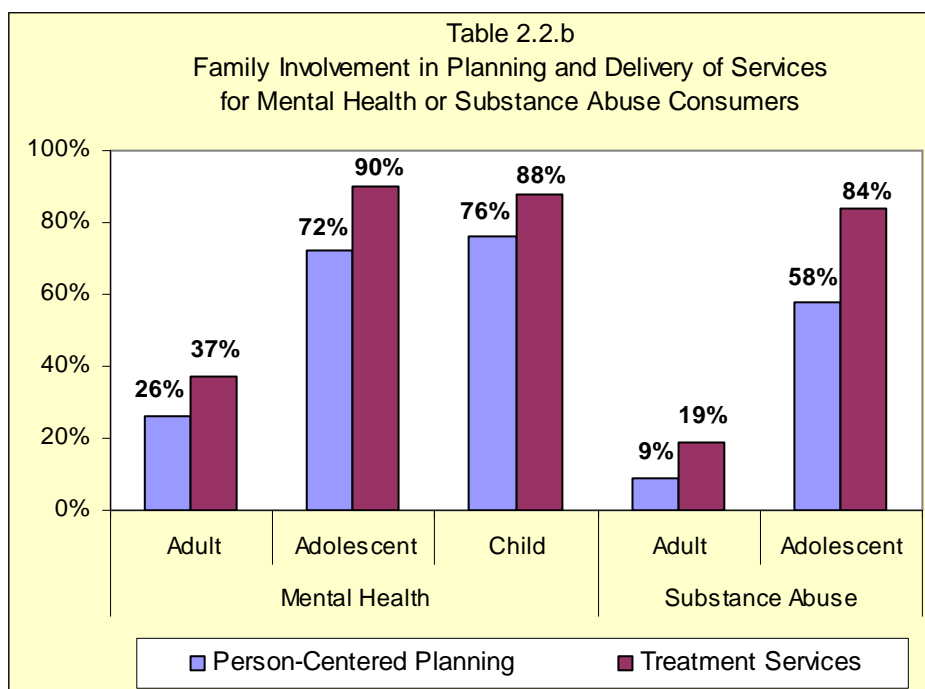


SOURCE: National Core Indicators Project, Adult Family and Family Guardian Surveys. Project Year 2005/06.

Consumers living away from home typically need and receive a more comprehensive array of services and supports than those living at home. As a result, their families are also more aware of available resources and how to navigate the service system. In contrast, people who care for a family member at home are often isolated from other families of individuals with disabilities and less connected to or aware of community resources that are available. The difference between these groups, as shown in Table 2.2.a above, suggests the need for more education to families with consumers living at home about how to connect to community resources that can support independence and community connections. In addition, families of consumers living away from home may need additional education on resources that can reduce dependence on the service system. The PCP process is the state's platform for providing that education to families and consumers. The PCP team is responsible for helping families learn about natural and paid supports that are available to foster self-direction and involvement of consumers in community life.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b): Table 2.2.b on the next page, shows that over almost two-thirds of families of children and adolescents with mental health disorders are involved in service planning and close to 90% are involved in service delivery. For families of adolescents with substance abuse disorders, well over half (58%) are involved with service planning and 84% are involved with service delivery. In contrast, relatively few adult consumers report their families being involved in planning or service delivery processes. Almost three-fourths (74%) of the families of adult MH consumers and 91% of the families of adult SA consumers had no involvement in the planning of services or the delivery of services. Just under two-thirds (63%) of adult MH consumers reported family involvement in service delivery compared to four-fifths (81%) of adult SA consumers.¹⁰

¹⁰ Only 8% of the families of adolescent MH consumers, 7% of families of child MH consumers, and 11% of the families of adolescent SA consumers reported having no involvement in either the planning or delivery of services. 63% and 81% of families of adult MH and adult SA consumers respectively have no involvement in either planning or delivery of services.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2006 - June 30, 2007 matched to 3-Month Update Interviews.

The greater involvement of parents of children and adolescents may reflect the state's efforts to institute a system of care that strongly encourages family ownership of service planning and delivery. In contrast, adult consumers are often reluctant to involve family members in their treatment. For this reason, the service system has historically placed less emphasis on encouraging family involvement for adult consumers. In taking a person-centered approach to services, providers have to strike a balance between honoring consumers' preferences and encouraging the involvement of an individual's natural support network.

The Division, LMEs and providers continue to incorporate person-centered thinking into all aspects of the service system. This is a major shift in philosophy that will require time, diligence and collaboration to achieve fully.

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to improve the attitudes, behaviors and/or functioning of persons with disabilities. It also refers to promising practices that are recognized nationally. The Substance Abuse and Mental Health Services Administration (SAMHSA) requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; reimbursing providers who adopt those practices; and providing oversight and technical assistance to ensure the quality of those services.

Measure 3.1: Persons Receiving Evidence-Based Practices

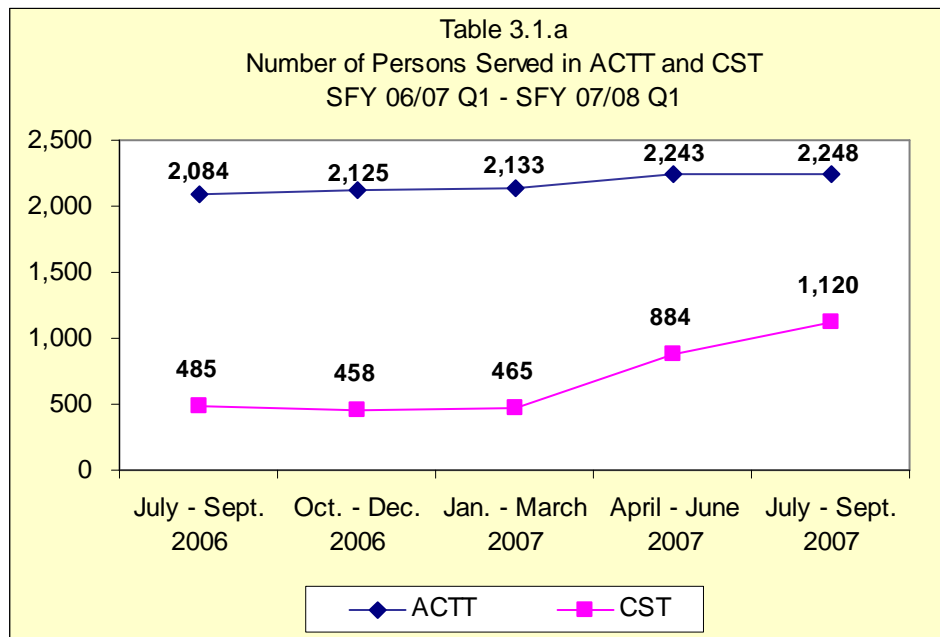
Consumers with Developmental Disabilities: The current 1915-c Medicaid waiver for persons with developmental disabilities, known as the Community Alternatives Program for MR/DD (CAP-MR/DD) has been in effect since September 1, 2005 and expires October 2008. The CAP-MR/DD Waiver has helped transform the system of services and supports for DD consumers by emphasizing person-centered planning, flexible services, and participant-centered outcomes.

The Division of MH/DD/SAS and the Division of Medical Assistance (DMA) are creating a system of tiered waivers to replace the current waiver as a way to enhance best practice approaches to delivering DD services and supports. The tiered waivers, designed to address the specific needs of four different populations of individuals with developmental disabilities, will:

- Tailor **service definitions to fit the needs of the specific population of each tier**, revising current definitions to ensure that components meet best practice standards for DD services and supports.
- Adapt the **standardized Person Centered Planning** format and process currently used with individuals who receive mental health and/or substance abuse services to fit the needs of DD consumers and to create standardization across the entire MH/DD/SAS system.
- Incorporate the **Supports Intensity Scale (SIS), a national strengths-based assessment tool**, into the person-centered planning process to ensure comprehensive attention to the intensity of supports needed to enable the individual to participate fully in their community. The SIS will also allow for statewide data collection on those individuals receiving services and supports on the tiered waivers to help the Division and DMA better plan and oversee DD service and support policies.
- Develop a **standardized Risk Assessment** tool and process to ensure that planning teams clearly identify and address in the PCP those areas of need related to risks experienced by the individual.
- Provide an **option for self-direction** by giving the individual and/or the family, rather than the provider agency, lead responsibility and authority for hiring, screening, training and supervision of individual support and service staff.
- Provide an **option for individual budget management** through a financial management service provided by a third-party entity to assist the individual or family to manage and distribute funds contained in the individual budget.

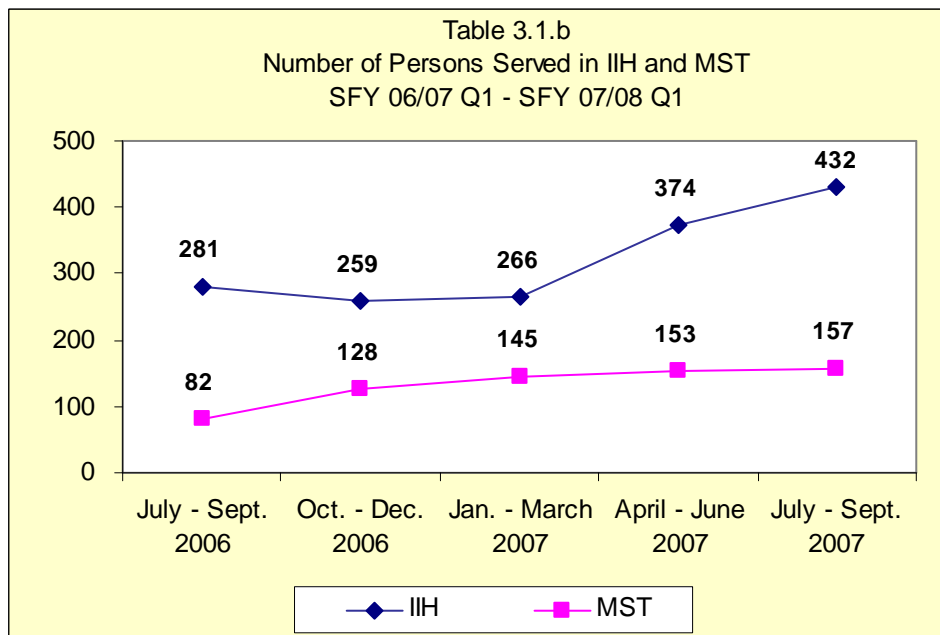
The goal in developing tiered waivers is to promote individualization of services and supports. All of these efforts will support our commitment to create a system that is responsive to the needs of individuals receiving services.

Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a, on page 16, the number of persons served in ACTT has been slowly climbing over the past five quarters (an increase of slightly less than ten percent), while the number of persons served in CST has increased 130% since the first quarter of SFY 2006-07.



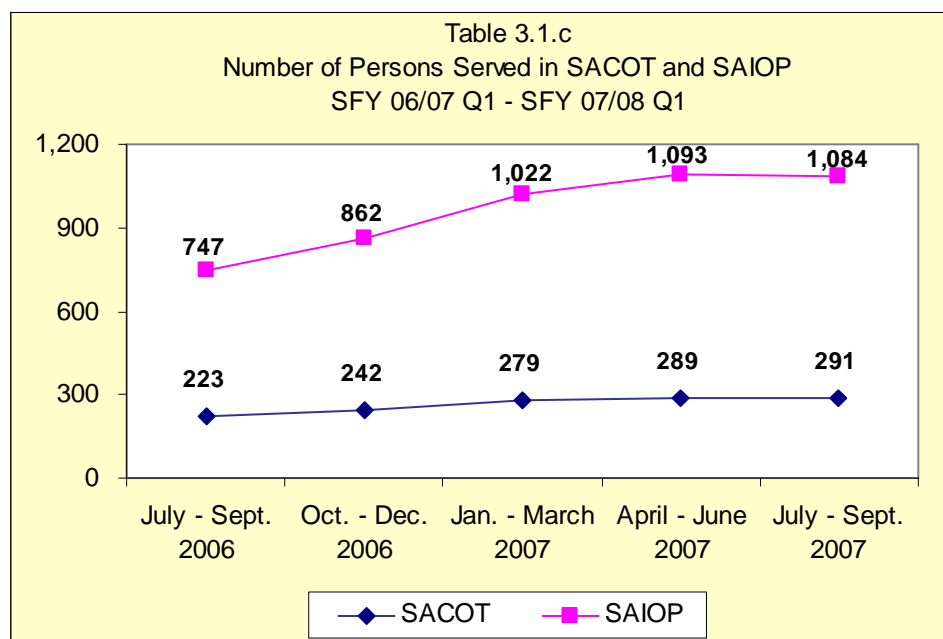
SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2007.

Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children who require residential and inpatient care. Table 3.1.b shows that the number of persons served in IIH has grown by more than 50% over the past five quarters. The number of persons served in MST has almost doubled since the first quarter of SFY 2006-07. The increase in MST reflects the expansion of statewide provider agencies and their coordination with LMEs.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2007.

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. Both SAIOP and SACOT have seen increases in the number of persons served during the last five quarters, as seen in Table 3.1.c below. SACOT has increased the number of persons served by 30% since the first quarter of SFY 2006-07, while SAIOP has seen an increase of 45%.



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - September 30, 2007.

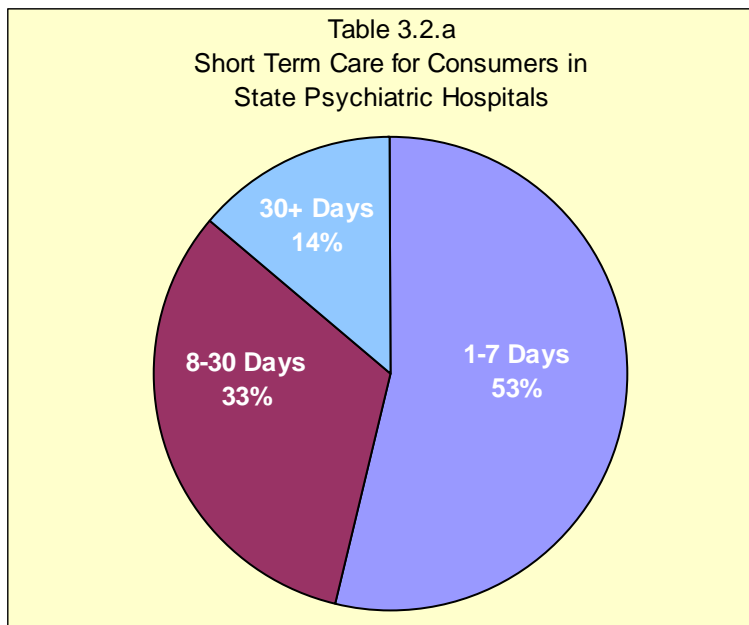
Faster growth in the use of best practice models has been hampered by the overuse of community support services. Changes in the requirements for providing and overseeing community support have begun to show the desired decline in the use of that service, as reported in the *Monthly Report to the General Assembly on Community Support Services*.

Measure 3.2: Management of State Facility Usage

Community Crisis Care and Short-Term Use of State Hospitals: North Carolina is committed to developing a service system in which individuals are served in their home communities whenever possible. This is a particularly critical component of care in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals to maintain contact with and receive support from family and friends, while reducing the use of state-operated psychiatric hospitals.

As has been reported previously, North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. The majority of states do not have short-term care units in their state hospitals. Instead acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. As a result North Carolina has served more people overall in its state hospitals and average lengths of stay have been shorter than the national average.

Table 3.2.a shows that 86% of discharges during the first two quarters of SFY 2007-08 (July through December 2007) were for consumers with lengths of stay for 30 days or less. Of the 7,369 discharges, 53% (n=3,946) were for consumers who discharged within 7 days of admission.

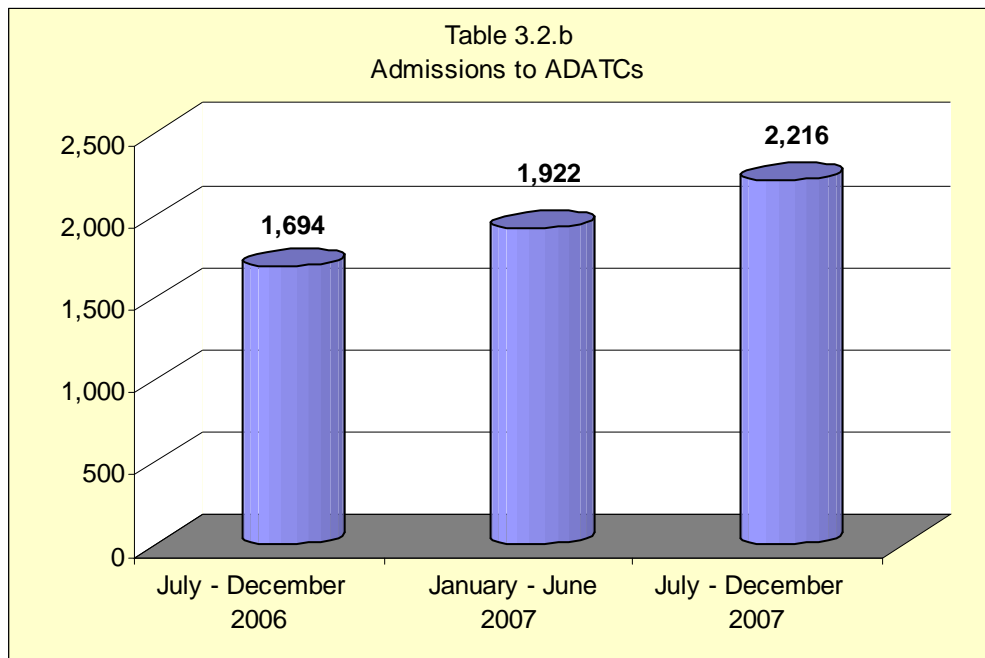


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)
Data for discharges during July 1 - December 31, 2007; N=7,369 discharges.

The use of state hospitals for short-term care reflects the lack of community-based crisis services, psychiatric units in private hospitals, and services to help individuals with complex, chronic disabilities maintain stability while living in their home communities. In particular, services such as partial hospitalization, acute treatment units and crisis stabilization services are needed, as well as more assertive community treatment teams, intensive outpatient substance abuse treatment, and specialized services for individuals who have both mental retardation and mental illness.

Development of a comprehensive community-based crisis services system and focusing state psychiatric hospital care on consumers with long-term needs is one of the five major objectives of *The State Strategic Plan: 2007-2010*. The LMEs are currently implementing plans for local comprehensive crisis service systems. The Division reports quarterly to the Joint Legislative Oversight Committee on their progress.

Acute Care in State Alcohol and Drug Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for acute care, the Division continues working to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. As shown in Table 3.2.b on the next page, admissions to all ADATCs has increased from 1,694 in the first two quarters of SFY 2006-07 to 2,216 in the first two quarters of SFY 2007-08 (a 31% increase).



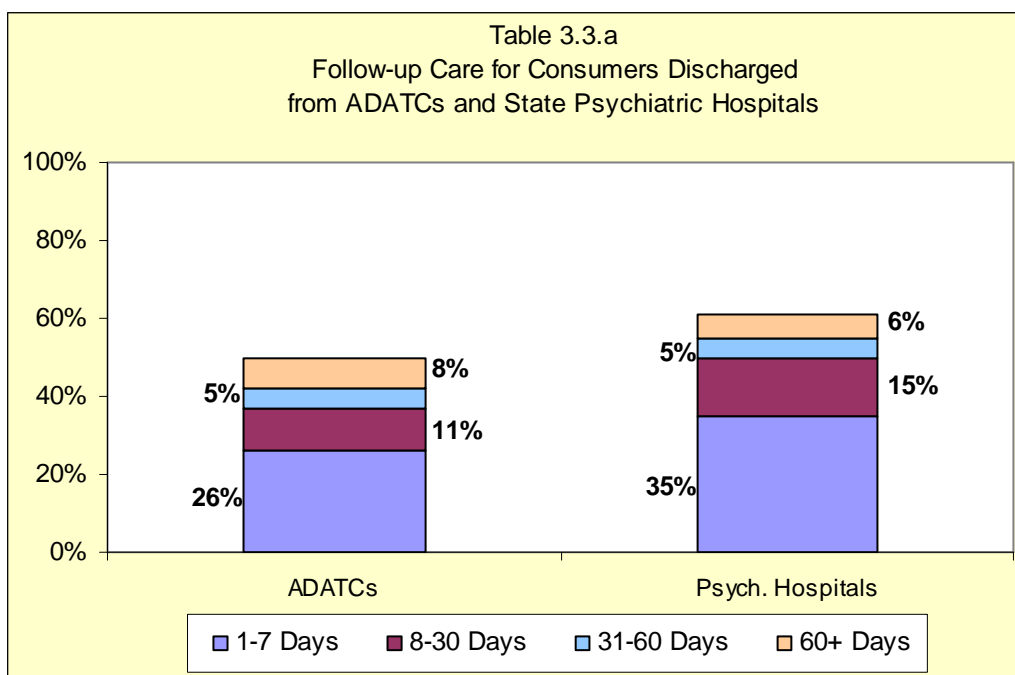
SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2006 - December 31, 2007.

Measure 3.3: Continuity of Care Following Discharge from State Facilities

Continuity of care for consumers after discharge from a state facility is critically important in preventing future crises and supporting an individual's successful transition to community living. A follow-up service within 7 days of discharge from a state facility is the current NC requirement in the *SFY 2008 DHHS-LME Performance Contract*.¹¹ Developmental centers adhere to a stricter best practice standard, which ensures that individuals moving to community settings receive extensive pre-discharge planning and immediate care upon discharge.

As shown in Table 3.3.a on the next page, about half (49% out of 833) of the persons discharged from state ADATCs are seen for follow-up care, with one-fourth (26%) receiving care within 7 days of discharge. Follow-up care for the state psychiatric hospitals is somewhat better. Almost three-fifths (60% out of 3,534) of persons discharged from state psychiatric hospitals receive follow-up care, with 35% being seen within 7 days.

¹¹ The Division adopted the Health Plan Employer Data and Information Set (HEDIS®) measure. However, best practice is for individuals with MH or SA disorders to receive care within 3 days. As the community service system stabilizes, the Division will increase expectations for timely follow-up community care.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges April 1 - June 30, 2007); Medicaid and State Service Claims Data (for claims submitted April 1 - December 31, 2007)

For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.¹² This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. Between January 1, 2007 and December 31, 2007, a total of fifteen individuals were discharged from the general population of the developmental centers to the community.¹³ All fifteen individuals went directly from services at the developmental centers to services in the community. Table 3.3.b on the next page shows the type of community setting to which the individuals moved¹⁴.

¹² Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

¹³ This number does not include persons discharged from specialty programs or respite care in the developmental centers.

¹⁴ Data above includes the three Developmental Centers and the O'Berry Center. Effective July 2007, O'Berry Center began to transition, to a neuro-medical treatment center.

Table 3.3.b
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
Calendar Year 2007

Time Period	Number of Individuals Moved to Community	Type of Community Setting
January – March 2007	4	1 to ICF-MR group home 2 to supervised living home 1 to natural family
April – June 2007	7	3 to ICF-MR group home 1 to supervised living home 2 to alternative family living home 1 to natural family
July – September 2007	3	1 to ICF-MR group home 1 to alternative family living home 1 to natural family
October – December 2007	1	1 to ICF-MR group home

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery-oriented service system. Recovery for persons with disabilities means having independence, stability and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

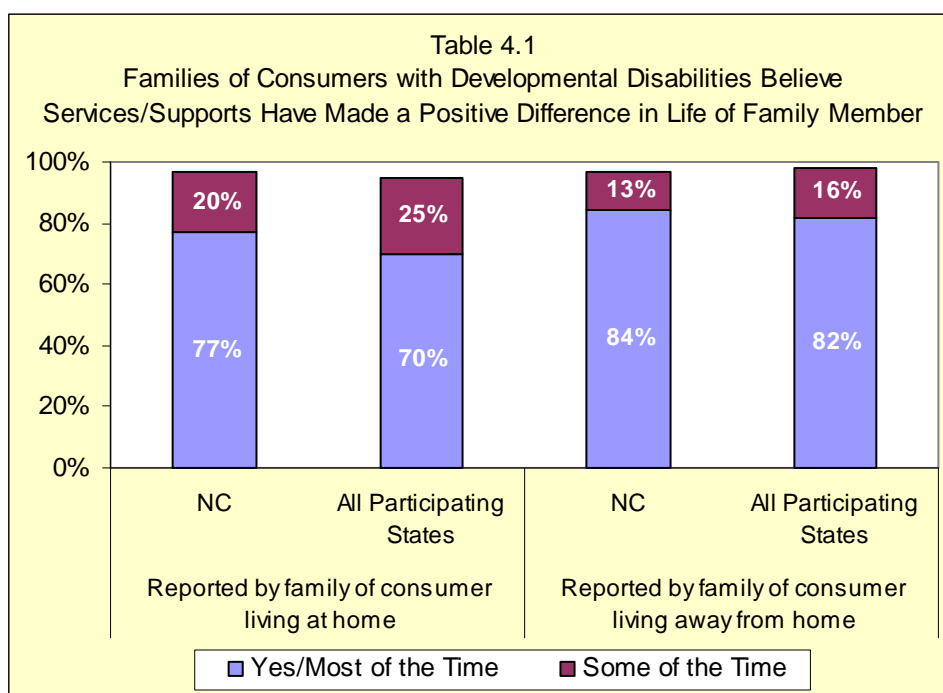
- Symptom reduction, abstinence, and/or behavioral improvements.
- Housing stability and independence.
- Employment and education.
- Social connectedness.

- Reduction in criminal involvement.

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of current information, the Division has identified improvements in housing and employment opportunities as strategic objectives for the next three years. Division and local agencies will continue analyzing consumer outcomes data to monitor progress in these areas and to identify other areas that require policy development or targeting of funds for training and technical assistance in clinical practice and for other service system enhancements.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

In annual interviews with family members of consumers with developmental disabilities in 2006, the large majority of family members in North Carolina reported they believe services and supports have made a positive difference in the life of their family member (see Table 4.1 below). North Carolina families reported slightly more positive perceptions of services and supports than the average among all states using the survey, with family members of consumers living away from home reporting more positively than family members of consumers living at home (84% compared to 77%). (See Appendix C for details on this survey.)

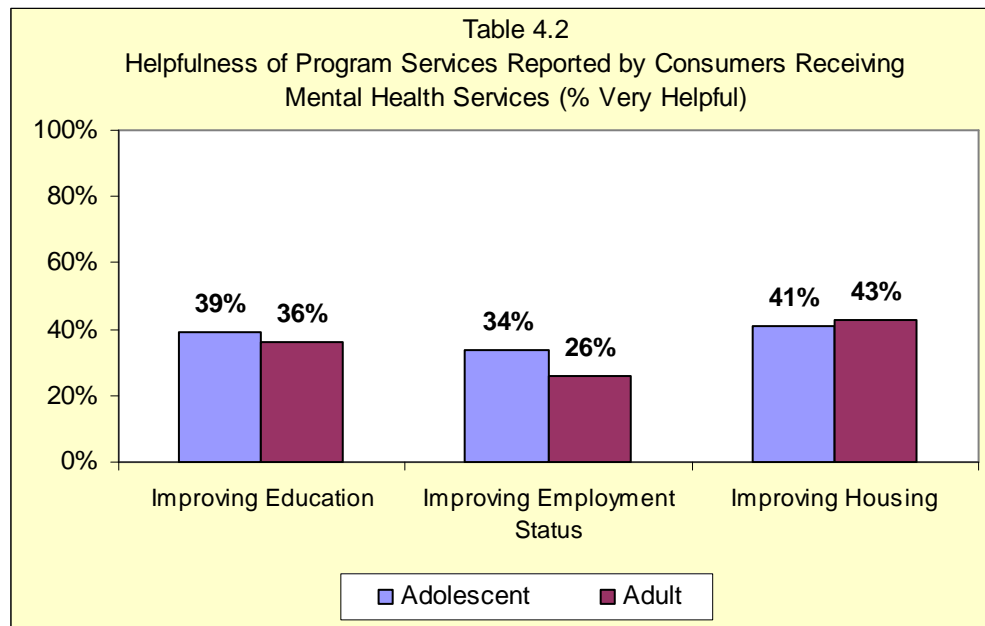


SOURCE: National Core Indicators Project, Adult Family and Family Guardian Surveys. Project Year 2005/06.

Measure 4.2: Outcomes for Persons with Mental Health Disorders

For persons with mental illness, housing and employment are important to regaining personal control of one's life. Successful engagement in services for even three months can begin to build the stability and control that improve consumers' lives and give them hope for further recovery.

Table 4.2 shows how mental health consumers in SFY 2006-07 perceived the impact of the first three months of treatment in three key areas of their lives. While three months is insufficient time to judge the long-term effect of treatment, building hope at the outset is an important factor in engaging individuals in their treatment and sustaining improvements over time (See Appendix C for details on the NC-TOPPS system used to collect this data.)



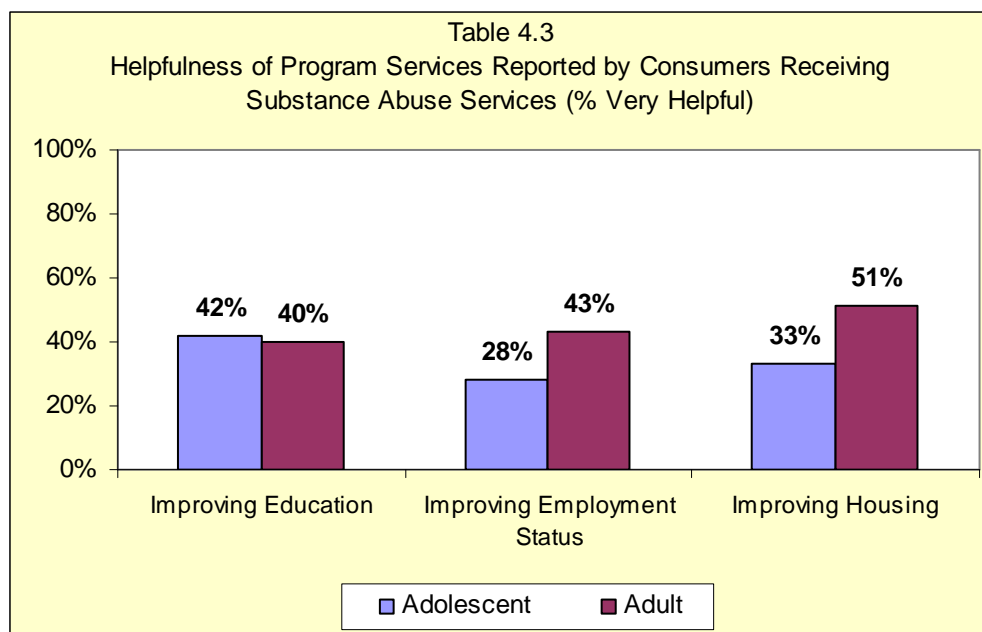
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2006 - June 30, 2007 matched to 3-Month Update Interviews.

- Slightly more adolescents (39%) than adults (36%) reported that services helped improve their education.
- More adolescents (34%) than adults (26%) reported improvements in their employment status.
- Over two-fifths of both adolescents and adults reported improvements in housing.

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

Individuals with substance abuse disorders, like those with mental illness, need stable housing and employment to regain personal control of their lives. Successful engagement in the first three months of service is especially critical for this population of consumers, because of the chronic, debilitating nature of addictions.

Table 4.3 shows how substance abuse consumers in SFY 2006-07 perceived the impact of the first three months of treatment in three key areas of their lives. Again, perceptions after three months of service is primarily an indicator of the individual's hope for recovery and engagement in services, both of which are key for achieving and sustaining improvements over time. (See Appendix C for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2006 - June 30, 2007 matched to 3-Month Update Interviews.

Overall, SA consumers' perceptions of care are much like those of MH consumers.

- Approximately two-fifths of adolescent and adult SA consumers reported that services helped improve their education.
- More adults (43%) than adolescents (28%) reported improvements in their employment status.
- More than half of adult SA consumers (51%) reported improvements in housing compared to one-third of adolescents (33%).

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.

- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

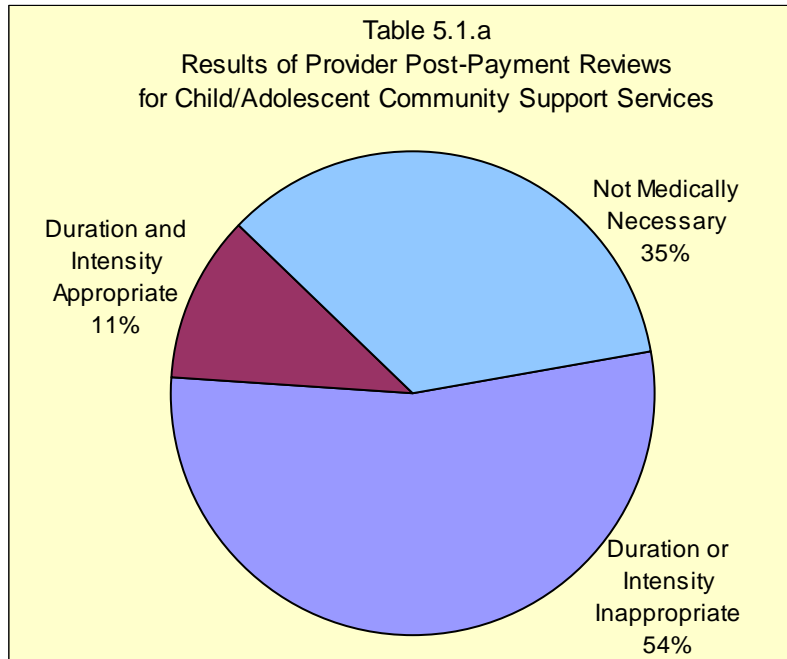
Measure 5.1: Assurance of Basic Service Quality

A major goal of system reform has been the separation of service delivery from service oversight. The LMEs are responsible for monitoring the quality of services provided by private agencies and assisting those agencies to resolve problems quickly and effectively. As part of efforts to monitor and control the use of community support services across the state, LMEs completed post-payment clinical reviews for all consumers who received at least twelve hours per week of community support services. These reviews, completed in September 2007, included 7,646 reviews of children and adolescents and 4,155 reviews of adults and involved 777 provider agencies.¹⁵

In September of 2007, DMH/DD/SAS submitted a Quality Assurance Evidence Package to CMS for assessment of North Carolina's CAP-MR/DD waiver. The North Carolina CAP-MR/DD waiver was assessed by CMS through the Evidence Package to determine that State assurances regarding the waiver are met. The State substantially or adequately met all required assurances including assurances that level of care determinations are adequate and effective, all aspects of Plan of Care requirements are addressed, and that assurances regarding oversight of health and welfare of waiver recipients are effective.

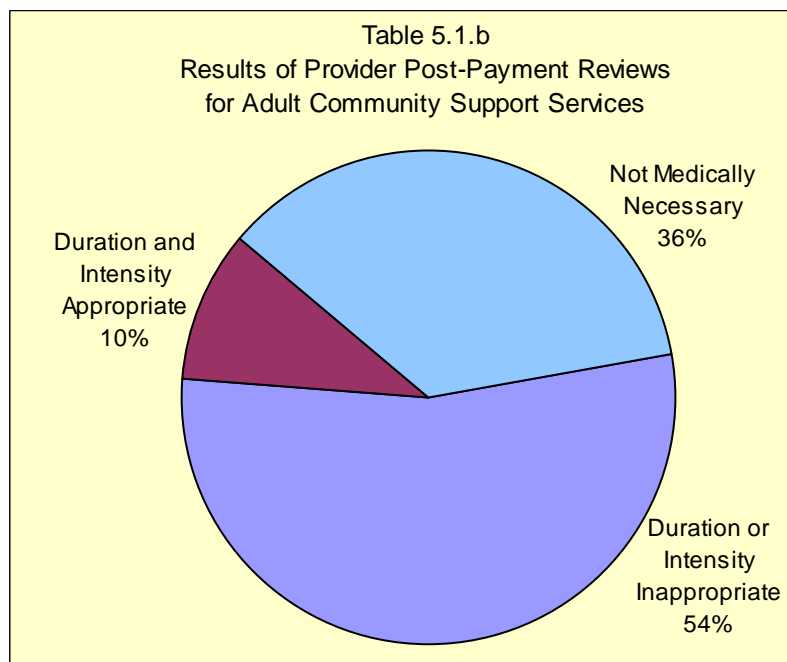
As shown in Table 5.1.a on the next page, only eleven percent of community support services provided to children and adolescents were considered medically necessary with appropriate duration and intensity. The reviews indicated that, of the individuals reviewed, 54% received community support services that were medically necessary, but not of appropriate duration or intensity. Just over one-third (35%) of individuals received services that were determined not to be medically necessary.

¹⁵ The information in Measure 5.1 has also been provided in the *Monthly Report to the General Assembly on Community Support Services*.



SOURCE: 2007 Clinical Post Payment Review data provided by LMEs to DMA, September 2007.

Results of reviews of adult community support services were much the same (see Table 5.1.b below). Only ten percent of adult services were considered medically necessary and 36% were not considered medically necessary. Well over half (54%) of the adult community support services were medically necessary, but not of appropriate duration or intensity.



SOURCE: 2007 Clinical Post Payment Review data provided by LMEs to DMA, September 2007.

As a result of the review process, almost 500 of the 777 providers reviewed (63%) have been referred to DMA's Program Integrity Section for further review and action, which may include referral to the Attorney General's Medicaid Investigation Unit.

Measure 5.2: Quality Improvement Activities

One of the salient principles of a quality management philosophy is that improving quality is everyone's responsibility not just that of the state oversight agency or the upper level management of any one agency within the system. As such, all participants within the system are accountable for their actions and must be empowered to improve the system. Applying this principle, organizations must find ways to support staff to improve their skills and work processes, share ideas and concerns, and participate in quality oversight and improvement processes. Externally, the different components of the system need to work as partners in identifying and resolving those issues that impact the local community or statewide service system.

In support of this principle, the Division's Quality Management Team sponsored a statewide conference in August 2007, to foster within the system the principles, practices, and processes that sustain system-wide collaboration and continuous quality improvement.

The conference brought together teams comprised of LME staff, provider staff and Consumer and Family Advisory Committee (CFAC) members from each local catchment area to learn about quality improvement techniques and to discuss with their team members data about their community's service system. The objectives of the conference were to:

- Increase understanding the need for sustainable collaborations and implement such collaborations across the system.
- Review and interpret performance data about the local service system.
- Evaluate performance information, identify problems and select quality improvement projects.
- Develop a system-wide focus on successful consumer outcomes

A total of 193 participants attended the conference, including 160 participants from community service systems and 33 state-level participants. Teams from every Local Management Entity were in attendance. During the course of the two day conference the participants heard from nationally renowned speakers on quality management and collaboration, learned ways of examining and assessing the multi-source data that is available to them, and experienced different ways in which innovative quality management projects can be developed, implemented, and evaluated within their specific system of care.

Domain 6: System Efficiency and Effectiveness

System efficiency and effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and diligent information management.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. The previous three-year Contract has been replaced by an annual Contract that will be revised and renewed each July. The LME-specific scope of work of past Contracts has been replaced by a

statewide scope of work that lays out the requirements for each function that the LME is contracted to fulfill. In addition, the contract contains statewide measures with annual performance standards and projected targets that the Division tracks and reports on its website quarterly. The LMEs are expected to develop and implement strategies for improving areas of weakness and achieving the Division's statewide targets.

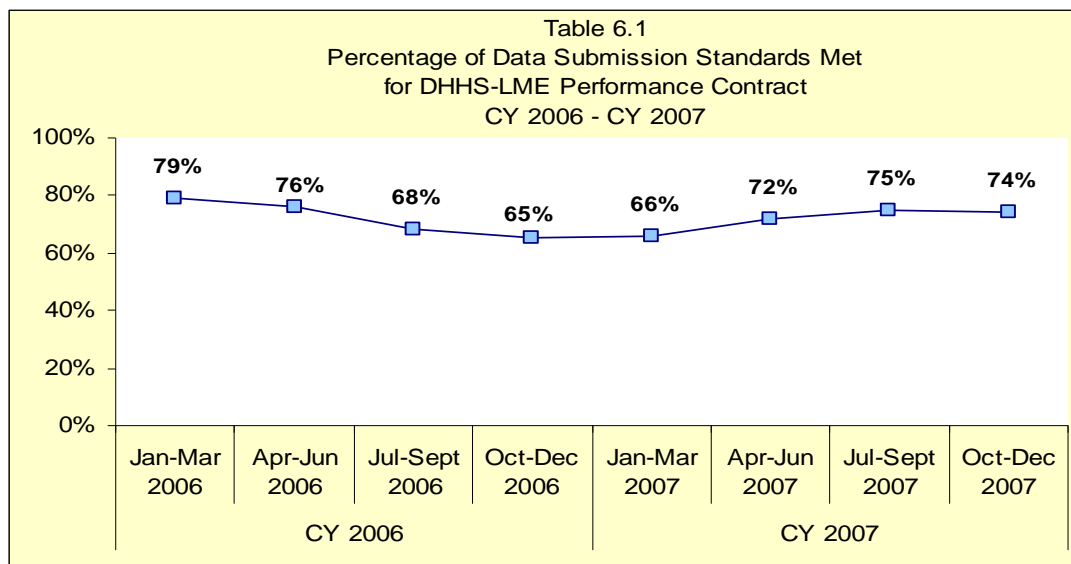
Measure 6.1: Business and Information Management

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

Consumer data, along with service claims data reported through the Integrated Payment and Reimbursement System, the Medicaid claims system, and the Healthcare Enterprise Accounts Receivable Tracking System, provide the information that the LMEs and the Division use to evaluate local and state system performance and to keep the Legislature informed of system progress through this report.

For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, local management entities' submission of timely and accurate information to the Division has been increasing since the end of CY 2006, after falling during the previous four quarters.



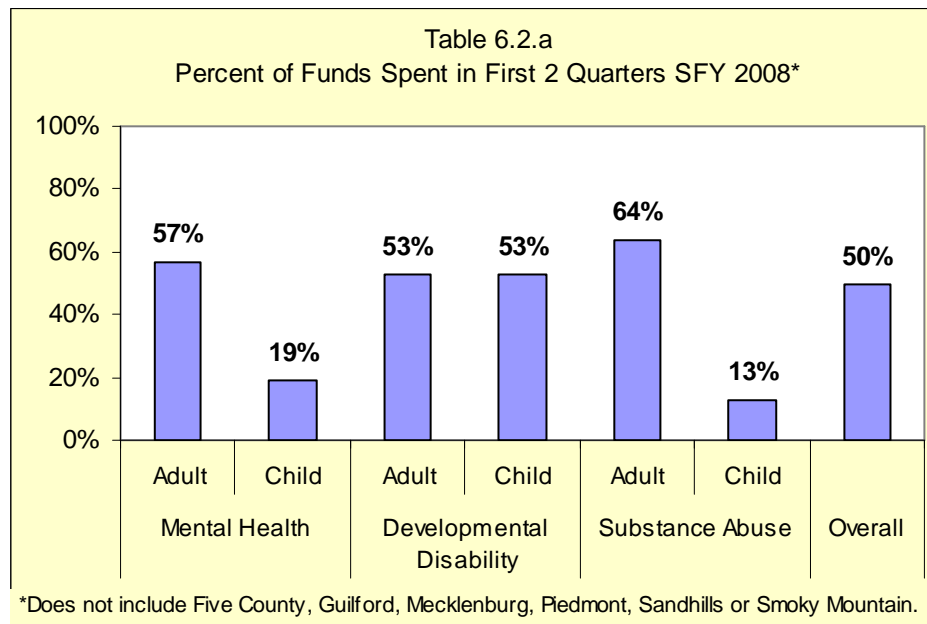
SOURCE: Data from Quarterly Performance Contract reports.

Since much of the LMEs' data on consumers now comes from private providers, additional training and good ongoing communication between LMEs and providers is necessary to ensure the timely flow of information. The Division provides ongoing monitoring and technical assistance to LMEs to help ensure the timely and accurate flow of information. The LMEs, in turn, use provider compliance with data reporting requirements, as a factor in determining their provider monitoring decisions.

Measure 6.2: Efficient Management of Service Funds

As stated above, service claims data reported through the Integrated Payment and Reimbursement System (IPRS) has been a major source of information that the Division uses to evaluate local and state system performance and to keep the Legislature informed of system progress through this report. Providing effective services requires careful management of limited fund allocations over the course of the fiscal year to ensure that funds are continuously available to serve those most in need, without being left unspent at the end of the fiscal year. Overspending of funds early in the year leaves no reserves for those who enter the system or continue to need services later in the year. Underspending of funds means that some who could have been served were not.

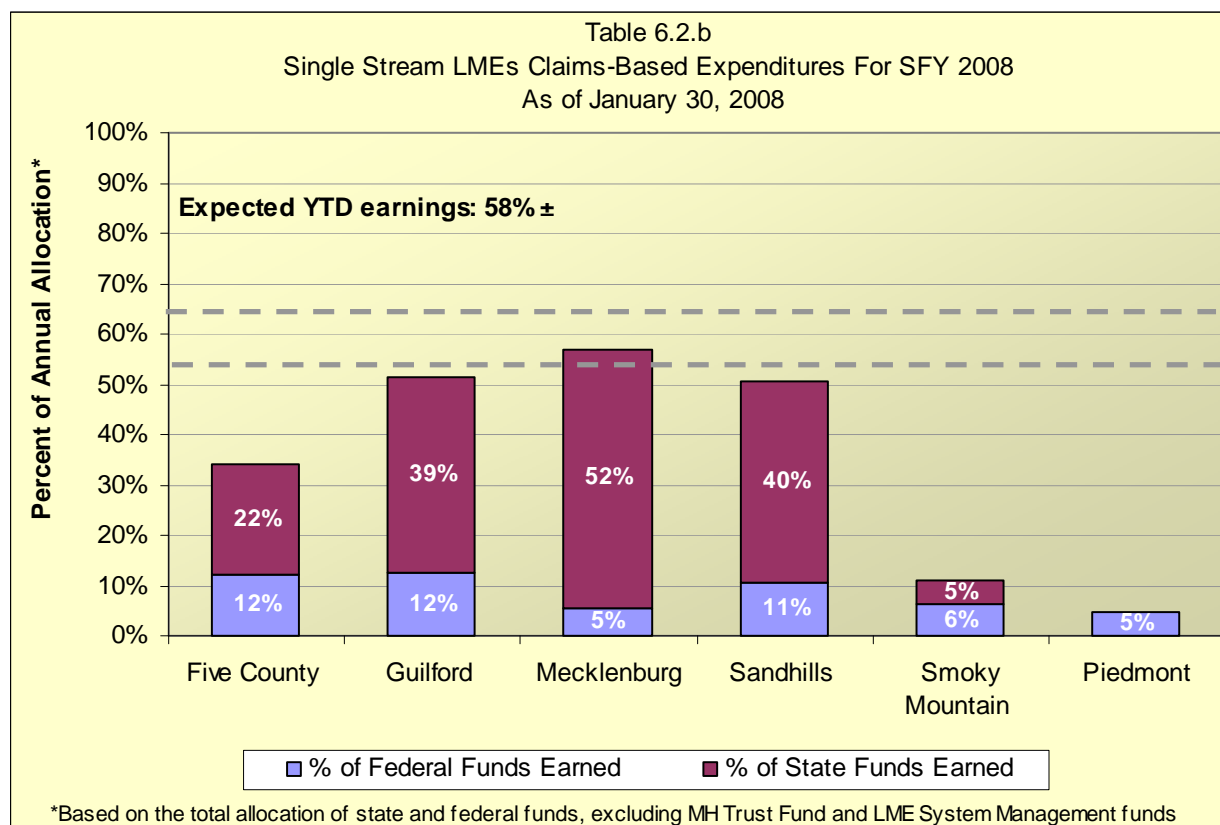
Table 6.2.a shows the average LME expenditures of state funds during the first two quarters of SFY 2008 by age-disability group, with an average of 50% spent across all age-disability groups.¹⁶ Of all the disability groups, the expenditures for adolescent substance abuse consumers lagged behind the others. In fact, only 13% of the allocations for adolescent substance abuse services were expended in the first two quarters of SFY 2008. Expenditures for child mental health consumers were not too far behind adolescent substance abuse consumers with only 19% of the allocations expended in the first two quarters.



SOURCE: Integrated Payment and Reporting System Service Data (for claims submitted July 1 - December 31, 2007)

¹⁶ Ideally 50% of funds would be spent by the end of the second quarter of the state fiscal year.

As indicated in Table 6.2.b below, only half (3 out of 6) of the LMEs receiving single-stream funding in the first six months of SFY 2008, have reported the expected volume of services for the first seven months of the fiscal year as shadow claims. The other half are far behind in reporting services that have presumably been delivered.



SOURCE: Integrated Payment and Reporting System Service Data (for shadow claims submitted by Single-Stream Funded LMEs, July 1 - January 31, 2008)

Three additional LMEs (Crossroads, Durham, East Carolina Behavioral Health) began receiving single-stream funding in the second quarter of the current fiscal year. The Division is monitoring their compliance with submission of shadow claims as well and will be working to ensure that all LMEs with single-stream funding understand the necessity of reporting shadow claims and comply with the requirement in their contract.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public and specific groups known to be at risk. Prevention education focuses on the nature of MH/DD/SA problems and how to prevent, recognize and address them appropriately. **Early intervention** activities target individuals who are experiencing early signs of an emerging condition to halt its progression or significantly reduce the severity and duration of its impact.

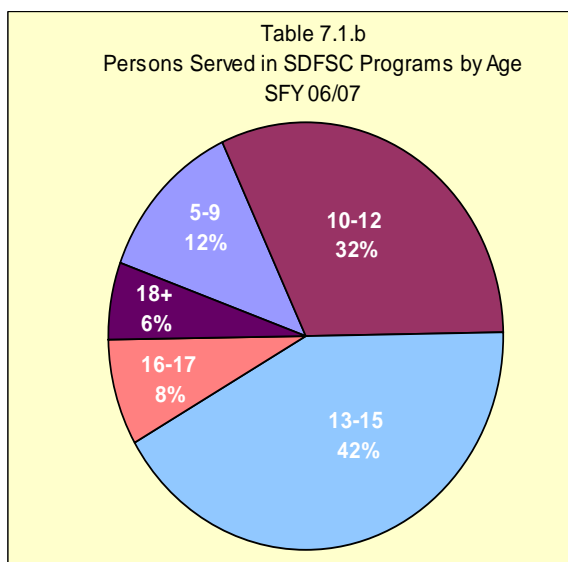
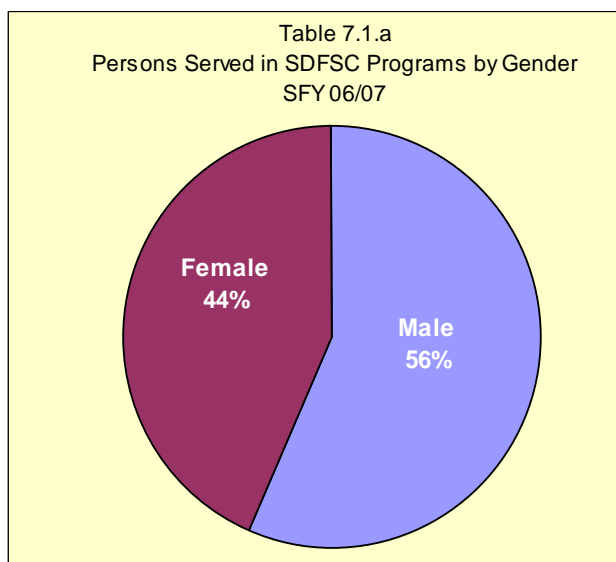
Preventing or intervening early in a potential problem is much more effective – both clinically and financially – than treating a disability that has already caused major impairments and negative consequences in an individual's and family's life. Increasing national attention is being given to

preventing or minimizing the impact of mental illness and developmental disabilities in consumers' lives. SAMHSA's National Outcome Measures (NOMS) emphasize the use of evidence-based programs to educate at all levels and intervene with individuals who may be experiencing early problems associated with substance use.

Measure 7.1: Safe and Drug Free Schools and Communities

The North Carolina Safe and Drug Free Schools and Communities (SDFSC) Program is a part of a national initiative designed to reduce illegal drug and alcohol use, as well as school violence, through education and prevention activities in public schools across the state. The program, funded by the U.S. Department of Education, involves parents and communities, in coordination with other federal, state, school and community efforts and resources, to foster a safe, drug-free learning environment that supports student academic achievement.

In SFY 2006-07, sixteen different evidence-based programs were used across the state to address the objectives of the SDFSC initiative. With SDFSC monies, North Carolina served a total of 1,944 individuals across fourteen LMEs in these evidence-based programs. Tables 7.1.a and 7.1.b show some of the demographics of the individuals served. The majority of persons served were male (n=1,095 persons or 56%) and between the ages of 13 and 15 (n=815 persons or 42%).



SOURCE: NC DMH/DD/SAS, SDFSC data. SFY06-07.

Appendix A: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ►	30-day substance use (non-use/reduction in use) ► Perceived risk/harm of use ► Age of first use ► Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ►	Increase in/no change in number of employed or in school at date of last service compared to first service ►	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ►	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ►	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ►	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness ¹	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ►	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ►	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ► Unduplicated count of persons served ►	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ►	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care ²	Clients reporting positively about outcomes ►	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost) ²	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices ²		Under Development	Total number of evidence-based programs and strategies

¹ For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.

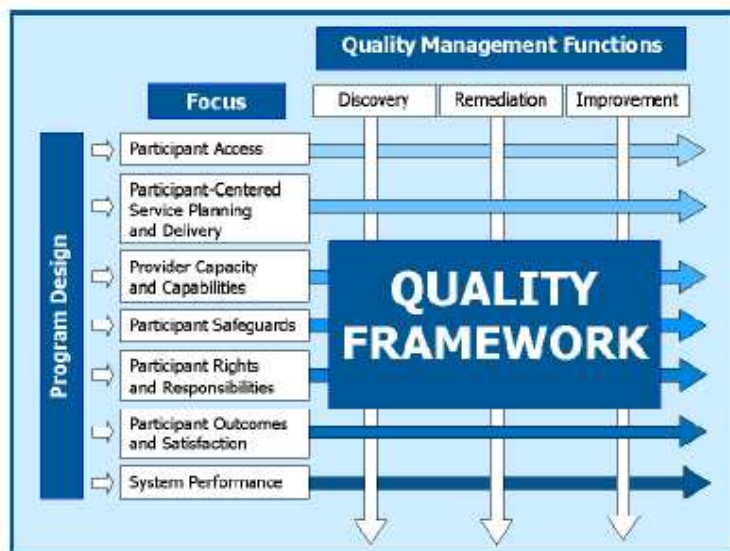
² Required by 2003 OMB PART Review.

Appendix B: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).



Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	Individuals have access to home and community-based services and supports in their communities.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.



Appendix C: Description of Data Sources

Domain 1: Access To Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

- Mental illness – Annual estimates from SAMHSA’s Center for Mental Health Services at: <http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp>

Adult estimate from URS Table 1: Number of Persons with Serious Mental Illness [sic], age 18 and older, by State, 2005, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: June 14, 2007.

Child/adolescent estimate from URS Table 1: Number of Children with Serious Emotional Disturbances [sic], age 9 to 17, by State, 2005, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 30, 2007.

Early childhood (ages 0-8) estimates from Glascoe and Shapiro, “Introduction to Developmental and Behavioral Screening.” Reprinted from *Pediatric Development and Behavior Online* <http://www.dbpeds.org> The Division applies the estimates established by CMHS for children ages 9-17 to those ages 0-8, since no consistent estimates have been adopted.
- Developmental Disabilities – Adult and child estimates from report by the US DHHS, Surgeon General (2001) based on data from the 1994 and 1995 National Health Interview Survey (NHIS) Disability Supplement, Phase I, Estimated Ages of People with MR/DD in US Non-Institutional Population. Prevalence rates for persons ages 3-5 = 3.8%, ages 6-16 = 3.2%, ages 17-24 = 1.5%, ages 25-34 = 0.9%, ages 35-44 = 0.8%, ages 45-54 = 0.7%, ages 55-64 = 0.5%, ages 65 and older = 0.4%.
- Substance abuse – Adult and child estimates from *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, <http://oas.samhsa.gov/nsduh.htm>.

The corresponding numbers of North Carolina residents in need in each age-disability group are calculated using US Census data for the relevant populations as of July 2007.

Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*): The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment Reimbursement System (IPRS) and/or Medicaid claims system for the time period October 1, 2006 through September 30, 2007) by the number of persons in need of services. The number of persons in need (the denominator) includes North Carolinians that the state’s MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. Persons with multiple disabilities are included in all relevant groups. Persons served in Piedmont LME are not included.

Table 1.2 Persons Seen Within Seven Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next seven days and multiplying the result by 100. The information comes from data submitted by LMEs

and published in the *Quarterly DHHS-LME Performance Contract Reports*. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the Performance Contract, including the quarterly reports, can be found on the web at: <http://www.ncdhhs.gov/mhddsas/performanceagreement/>.

Domain 2: Individualized Planning and Supports

Enrolled Providers: The number of provider agencies providing community-based services comes from the Medicaid claims system. As of December 31, 2007, a total of 2,023 community intervention service agencies and 841 providers of Community Alternatives Program for Mental Retardation and Developmental Disabilities (CAP-MR/DD) Waiver services were actively enrolled in the Medicaid claims reimbursement system. An additional 702 child residential facilities and 327 Intermediate Care and Skilled Nursing Facilities (not owned by the state) are enrolled in Medicaid, but not included in the total of community-based service providers reported in Measure 2.1.

Tables 2.1.a Choice Among Persons With Mental Health And Substance Abuse Disabilities: The data presented in these tables come from clinician-to-consumer initial interviews that occurred between July 1, 2006 and June 30, 2007 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at <http://nctopps.ncdmh.net/>. The interviews included 25,834 adult MH consumers, 13,054 adolescent MH consumers, 10,111 child MH consumers, 13,976 adult SA consumers, and 1,427 adolescent SA consumers. Notes about the data: Private methadone consumers are not included. Within age groups, mental health and substance abuse consumers overlap due to co-occurring disabilities.

Tables 2.1.b Choice Among Persons With Developmental Disabilities: The data presented in these tables are from in-person interviews with North Carolina consumers in the spring of 2006, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 500 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: <http://www.hsri.org/nci/index.asp?id=reports>.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Providers of Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Table 3.2.a Short Term Care in State Psychiatric Hospitals: The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) HEARTS discharges for the period July 1 - December 31, 2007. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, and over 30 days) are calculated by dividing the total number of discharges during July 1-December 31, 2007 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.2.b Admissions to ADATC Facilities: These data come from the Division's HEARTS data for July 2006 through December 2007.

Table 3.3.a Follow-up Care for Consumers Discharged from ADATCs and State Psychiatric Hospitals: The data come from HEARTS direct discharges during the period April 1 - June 30, 2007 and Medicaid and State Service Claims data for April 1- December 31, 2007. Data from Piedmont LME are not included. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days, 30-60 days, and greater than 60 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care.

Table 3.3.b Follow-up Care for Consumers Discharged from State Developmental Centers: These data come from reports submitted quarterly by the developmental centers to the Division. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Tables 4.1 Service Outcomes For Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.a above.

Tables 4.2 and 4.3 Service Outcomes for Individuals With Mental Health And Substance Abuse Disabilities: This information comes from NC-TOPPS, described in Tables 2.1.b.

Domain 5: Quality Management

Table 5.1.a and Table 5.1.b Assurance of Basic Service Quality: The information comes from the 2007 Clinical Post Payment Review data conducted by LMEs and reported to DMA in September 2007.

Domain 6: Efficiency and Effectiveness

Table 6.1 Effective Management of Information: The data for information management come from calculations of compliance for requirements in the DHHS-LME Performance Contract.

Table 6.2 Percent of Funds Spent: The data for Table 6.2.a on expenditure of funds come from service claims submitted to the Integrated Payment and Reporting System (IPRS) between July 1 and December 31, 2007 by LMEs that are not single-stream funded. The data for Table 6.2.b on shadow claim submissions come from service claims submitted to the IPRS by LMEs with single-stream funding between July 1 and December 31, 2007. Submitted claims that are reimbursed with federal funds on a unit-cost basis or denied due to lack of funds (a fiscal denial) are included in the numerator, along with federal funds paid on an expense basis. The denominator includes total annual allocations, excluding funds for LME system management and funds received from the Mental Health Trust Fund.

Domain 7: Prevention and Early Intervention

Table 7.1.a and Table 7.1.b Assurance of Basic Service Quality: The information comes from the Division's data on Safe and Drug Free Schools and Communities for SFY 20 06/07.